STANDARDS OF CARE

Los Angeles County Commission on HIV

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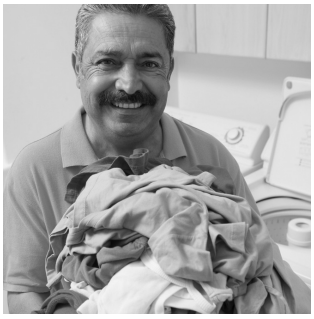


STANDARDS OF CARE

Los Angeles County Commission on HIV

HOUSING CASE MANAGEMENT SERVICES

EXECUTIVE SUMMARY

SERVICE INTRODUCTION

Housing case management services are designed to assist people living with HIV to locate, acquire, finance and stably maintain decent, safe, affordable and appropriate housing. Appropriate housing means that clients are provided with housing services and referrals that are congruent with their health, mental health, psychosocial and cultural needs. In contrast to other case management or care coordination activities, housing case management focuses primarily on the activities and concerns associated with obtaining and maintaining safe, decent and affordable housing that is appropriate for clients' needs.

Housing case management services include:

- Outreach
- Engagement
- Intake
- Comprehensive screening and referral as appropriate and needed
- Housing assessment
- Development of individual housing plans
- Individual housing plan implementation, evaluation, monitoring and updating
- Client retention
- Case closure
- Housing coordination

The goals of housing case management services for people living with HIV include:

- Assisting clients' access to, or maintenance of, stable ongoing residency
- Identifying realistic housing choices and contingencies
- Increasing clients' access to support services that aid in their ability to live independently

SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

At present, housing case management services are unlicensed. All housing case management services will be provided in accordance with Commission on HIV guidelines and procedures, and federal, state and local laws, regulations, policies and guidelines.

Housing case managers will complete the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy—Benefit Specialty 101 training, and requisite Housing Opportunities for Persons with AIDS (HOPWA) and Housing and Urban Development (HUD) trainings as required by the Los Angeles Housing Department.

A case management-experienced, Master's degree-level or Doctoral candidate mental health professional will provide ongoing client care-related supervision for all housing case managers.

SERVICE CONSIDERATIONS

General Considerations: Housing case management services will respect the inherent dignity of each person living with HIV they serve. Services will be client-driven, aiming to increase a client's sense of empowerment, self-advocacy and medical self-management, as well as enhancing the overall health status of people living with HIV. All housing case management services will be culturally and linguistically appropriate to the target population.

Outreach: Programs providing housing case management services will conduct outreach activities to potential clients and the community to promote the availability of and access to housing case management services.

Engagement: Engagement provides a context for assessing needs, defining service goals and agreeing on a plan for delivering identified services. Because many homeless individuals have been unserved or underserved by agencies, they require slower and more cautious service approaches.

Assisting people to find safe, affordable housing.

Intake: Client intake determines program eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client. Programs will assess individuals in crisis to determine what other interventions are appropriate, either within the agency, or by immediate referral.

Comprehensive Screening and Referral: The issues that may affect referral, placement and maintenance of appropriate housing are complex and may encompass varying psychosocial challenges and require careful screening. Housing case managers play a critical role in assisting homeless and low-income families and individuals living with HIV/AIDS with access to stable housing and supportive services along the entire continuum of care.

Housing Assessment: Client housing assessments will be completed using all components of the initial comprehensive screening and based upon a client's level of functioning and/or current need.

Individual Housing Plan (IHP): Information gathered in the comprehensive screening and housing assessments will be used to develop the client's IHP. Working closely with the client, the housing case manager will formulate a housing plan tailored to the specific needs of the client.

Implementation of IHP, Evaluation, Monitoring and Updating Client Retention: Implementation, evaluation, monitoring and updating of the IHP involve ongoing contact and interventions with (or on behalf of) the client to achieve the goals detailed in the IHP, evaluate whether services are consistent with the IHP and determine any changes in the client's circumstances (e.g., health status, family composition, income/employment, behavioral health needs) that could impact the IHP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion.

Case Closure: Case closure is a systematic process for disenrolling clients/families from active housing case management services. The process includes formally notifying clients of pending case closure and completing a case closure summary to be kept on file in the client record.

Housing Coordination: Housing case managers must also market their housing services to

new and existing private, public, nonprofit, and/or for profit agencies/owners/managers in the housing case manager's geographic area.

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all housing case management staff will be able to provide linguistically and culturally age-appropriate care to people living with HIV and complete documentation as required by their positions. Housing case management staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations.

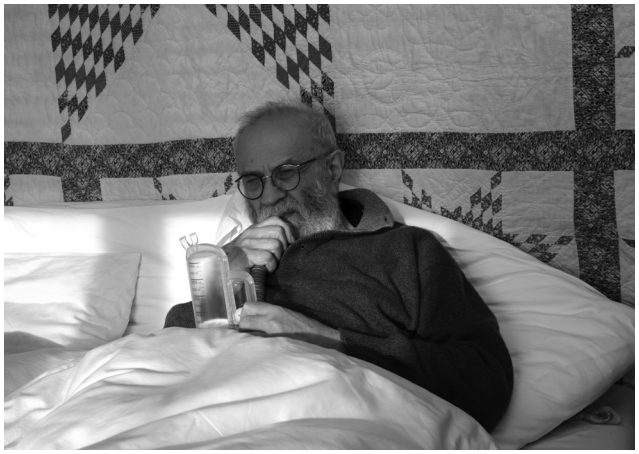
Housing case managers will hold a Bachelor's degree in an area of human services; a high school diploma (or GED equivalent) and at least one year's experience working as an HIV case manager; or at least three years' experience working in a related health services field.

Further, housing case management staff will have:

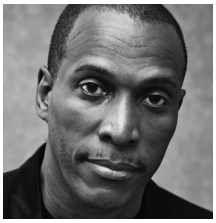
- Knowledge of HIV/AIDS and related issues
- Knowledge of the Los Angeles County HIV continuum of care and the role of housing case management in the HIV continuum of care
- Effective interviewing and assessment skills
- Ability to appropriately interact and collaborate with others
- Effective written/verbal communication skills
- Ability to work independently
- Effective problem-solving skills
- Ability to respond appropriately in crisis situations
- Effective organizational skills

All housing case managers will complete DHSP's Benefits Specialty 101 training and, requisite HOPWA and HUD trainings as required by the Los Angeles Housing Department.

Client care case management supervision will be provided by a Master's degree-level mental health professional (social work, counseling, nursing with specialized mental health training, psychology, or doctoral candidate in any of these fields) with case management experience and appropriate professional credentials. Case management supervisors will complete OAPP's Case Management Supervisor Training within six months of being hired.







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HOUSING CASE MANAGEMENT SERVICES

SERVICE INTRODUCTION

Housing case management services are designed to assist people living with HIV to locate, acquire, finance and stably maintain decent, safe, affordable and appropriate housing. Appropriate housing means that clients are provided with housing services and referrals that are congruent with their health, mental health, psychosocial and cultural needs. In contrast to other case management or care coordination activities, housing case management focuses primarily on the activities and concerns associated with obtaining and maintaining safe, decent and affordable housing that is appropriate for clients' needs.

Services are provided by RN case managers.

Housing case management services include:

- Outreach
- Engagement
- Intake
- Comprehensive screening and referral as appropriate and needed
- Housing assessment
- Development of individual housing plans
- Individual housing plan implementation, evaluation, monitoring and updating
- Client retention
- Case closure
- Housing coordination

All programs will use available standards of care to inform clients of their services and provide services in accordance with legal and ethical standards. The importance of maintaining confidentiality is of critical importance and cannot be overstated. All programs must comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

The goals of housing case management services for people living with HIV include:

- Assisting client access to, or maintenance of, stable ongoing residency
- Identifying realistic housing choices and contingencies
- Increasing client access to support services that enable them to live independently

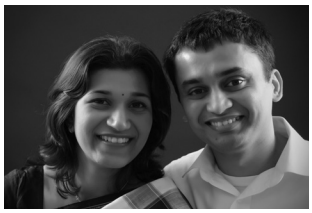
The Los Angeles County Commission on HIV and the Division of HIV and STD Programs (DHSP)—formerly referred to as the Office of AIDS Programs and Policy—have developed this standard of care to set minimum quality expectations for service provision and to

guarantee clients consistent care, regardless of where they receive services in the County. Recurring themes in this standard include:

- Housing case management services will respect the dignity and self determination of clients.
- Services will be based on a comprehensive housing assessment, around which housing plans and related services are developed.
- Case management staff require specialized training and ongoing client care-related supervision.

This document represents a synthesis of published standards and research, including:

- *HOPWA Program RFP*, City of Los Angeles, Los Angeles Housing Department (LAHD), 2007
- *Notice: CPD 06-07, Standards for HOPWA Short-Term Rent, Mortgage, and Utility (STRMU) Payments and Connections to Permanent Housing, Issued August 3, 2006*
- *Case Management, Psychosocial Standard of Care*, Commission on HIV, Los Angeles County, 2006
- *Housing Case Management presentation* by Mariah Ybarra, "Getting to Know Your Neighbor" conference, January 8, 2010
- *Housing Opportunities for Persons With AIDS (HOPWA) Grantee Oversight Resource Guide*, U.S. Department of Housing and Urban Development, Office of Community Planning and Development, August 27, 2008
- *To Dance With Grace: Outreach & Engagement To Persons on the Street*, Sally Erickson, M.S.W. and Jaimie Page, M.S.W., L.S.W., 1998 National Symposium on Homelessness Research
- Conversation with local housing case management experts



SERVICE/ORGANIZATIONAL LICENSURE CATEGORY

At present, housing case management services are unlicensed. All housing case management services will be provided in accordance with Commission on HIV guidelines and procedures, and federal, State and local laws, regulations, policies and guidelines.

Housing case managers will complete DHSP's Benefit Specialty 101 training and, requisite Housing Opportunities for Persons with AIDS (HOPWA) and Housing and Urban Development (HUD) trainings as required by the Los Angeles Housing Department.

A case management-experienced, Master's degree-level or Doctoral candidate mental health professional will provide ongoing client care-related supervision for all housing case managers.

DEFINITIONS AND DESCRIPTIONS

Comprehensive screening and referral is a cooperative and interactive face-to-face interview process during which the client's medical, physical, psychosocial, environmental and financial strengths, needs and resources are identified.

Engagement is the process of establishing and building trust and clear communication with clients. Engagement provides a context for assessing needs, defining service goals and agreeing on a plan for delivering identified services. Because many homeless individuals

have been unserved or underserved by agencies, they require slower and more cautious service approaches. The period from initial contact to engagement can range from a few hours to two years.

Family household consists of two or more related persons, or one or more eligible person or persons, who are living with one another and are determined to be important to their care or well-being, financially and emotionally.

Housing coordination involves developing a network of private and public housing providers willing and able to work with persons living with HIV/AIDS and serving as a liaison between property owners/managers and clients to ensure safety, maintenance and habitability standards and positive relationships.

Housing assessment gathers information about temporary and permanent housing needs, finances, housing history, behavioral history, and other service needs.

Individual housing plan (IHP) identifies households' ongoing housing needs and options for assistance, including budgeting and money management.

Outreach is the initial and most critical step in connecting, or reconnecting, homeless individuals to health and support services. A process, rather than an outcome, outreach focuses on establishing rapport and engaging individuals in services they need and will accept. In addition, outreach expands the network of private and public housing providers willing and able to work with affordable housing programs.

Reassessment is an opportunity to periodically reassess a client's needs and progress in meeting the objectives as established within the IHP.

IHPs identify assistance with budgeting.

HOW SERVICE RELATES TO HIV

At the end of 2013, approximately 60,050 people were estimated to be living with HIV infection in Los Angeles County. Los Angeles County comprises 40% of the total AIDS cases in the State of California (Epidemiologic Profile of HIV in Los Angeles County, 2013).

The effects of unstable housing on people living with HIV have been well documented. A 2005 study by Waldrop-Valverde and Valverde found that homeless or marginally housed HIV-positive injection drug users reported higher levels of anxiety, depression and perceived stress than their non-homeless counterparts. HIV-positive clients living in poor housing conditions are more likely to be non-adherent to their medical treatment (Spire et al. 2002). Homelessness has been shown to be associated with higher utilization of emergency department and inpatient services and to exacerbate the health care needs of people living with HIV (Masson et al., 2004).

Homeless clients are less likely than the stably housed to see a physician regularly, or do so for a significantly shorter period of time. Homeless people living with HIV are also less likely to see the same physician or group of physicians at each outpatient visit, suggesting that they may be receiving less adequate health care than the stably housed. As a result, this vulnerable population is more likely to experience adverse clinical outcomes (Smith et al., 2000).

Stable housing has been shown to be an important factor in health outcomes for people

living with HIV (Kenagy et al., 2003). Programs that address immediate needs such as housing have been found to be more appealing to injection drug users than programs offering HIV medical care alone. Such programs can be used as incentives to motivate hard to reach clients to engage in other services (Molitor et al., 2005).
Case management services have been shown to be an essential component in the comprehensive care of people living with HIV (Mitchell & Linsk, 2001). The effect of case managers is felt both directly and through their role as gatekeepers to a variety of other supportive services (Messeri et al., 2002).

Connecting clients to resources is time-consuming and complex, often involving a mix of advocacy and mediation (Chernesky & Grube, 2000). Even brief interventions by case managers have been associated with significantly higher rates of linkages to HIV care services (Gardner et al., 2005).

SERVICE COMPONENTS

Housing case management services are designed to assist people living with HIV to locate, acquire, finance and maintain affordable and appropriate housing. Appropriate housing means that clients are provided with housing services and referrals that are congruent with their health, mental health, psychosocial and cultural needs. In contrast to other case management or care coordination activities, housing case management services focus primarily on the activities and concerns associated with obtaining and maintaining safe, decent and affordable housing that is appropriate for clients' needs.

Comprehensive screening and referral is necessary for housing case managers to determine the most appropriate housing referrals for their clients. While these assessments may uncover a multitude of psychosocial needs, the housing case manager's primary purpose is to facilitate the acquisition and maintenance of appropriate housing for their clients. The resolution of other needs that come to light in the assessment process will be completed through referral to care coordination services and/or the needed services themselves. In no way are housing case management services designed to replace care coordination services.

Housing case management services include:

- Outreach
- Engagement
- Intake
- Comprehensive screening and referral
- Housing assessment
- Development of individual housing plans
- Individual housing plan implementation, evaluation, monitoring and updating
- Client retention
- Case closure
- Housing coordination

Housing case management services will respect the inherent dignity of the client. Services will be client-driven, aiming to increase a client's sense of empowerment, self-advocacy and medical self-management, as well as enhancing the client's overall health status. All housing case management services will be culturally and linguistically appropriate to the target population.

OUTREACH

Outreach involves interacting with both potential clients and the community to ensure that individuals needing housing can access a wide variety of housing resources. Programs providing housing case management services will conduct outreach activities to potential clients and the community to promote the availability of and access to housing case management services. Outreach is the initial and most critical step in connecting, or reconnecting, homeless individuals to health and support services. A process, rather than an outcome, outreach focuses on establishing rapport and engaging individuals in services they need and will accept. Possible areas of community outreach include HIV and non-HIV service providers, public health departments, food banks, education centers, resources fairs, public housing authorities, private landlords and rental agents and non-profit/ affordable housing developers.

Outreach activities can include (but not be limited to):

- Networking with other providers
- Posting flyers targeted to potential clients
- Attending community meetings

STANDARD	MEASURE
Housing case management programs will outreach to potential clients.	Outreach plan on file at provider agency.
• Housing case management programs will outreach to HIV and non-HIV service providers, public health departments, food banks, education centers, resources fairs, public housing authorities, private landlords and rental agents and non-profit/affordable housing developers.	Networking activities on file at provider agency.

ENGAGEMENT

Engagement is the process of establishing and building trust and clear communication with clients. It provides a context for assessing needs, defining service goals and agreeing on a plan for delivering identified services. Because many homeless individuals have been unserved or underserved by agencies, they require slower and more cautious service approaches. The period from initial contact to engagement can range from a few hours to two years and may require multiple encounters to develop a strong working relationship. Engagement involves active listening, being non-judgmental, and meeting clients where they are. Housing case managers should capitalize on the client's interest in housing by providing them with information in various housing options and encouraging the client to make the choice.

STANDARD	MEASURE
Housing case management programs will engage potential clients.	• Number of encounters for engagement • Client satisfaction
Clients provided information on housing options.	• Client chart documents housing options provided to client • Acknowledgement from client that housing options provided and preferences made

INTAKE

Client intake determines program eligibility and includes demographic data, emergency contact information, next of kin and eligibility documentation. When possible, client intake will be completed in the first contact with the potential client. Programs will assess individuals in crisis to determine what other interventions are appropriate, either within the agency, or by immediate referral.

In the intake process and throughout housing case management service delivery, client confidentiality will be strictly maintained and enforced. All programs will follow HIPAA guidelines and regulations for confidentiality. As needed, Release of Information forms will be gathered. These forms detail the specific person/s or agencies to or from whom information will be released as well as the specific kind of information to be released. New forms must be added for individuals not listed on the most current Release of Information (specification should indicate the type of information that can be released).

As part of the intake process, the client file will include the following information (at minimum):

- Written documentation of HIV diagnosis
- Proof of Los Angeles (LA) County residency (including homeless affidavit signed by client and worker)
- Verification of financial eligibility for services
- Date of intake
- Client name, telephone number, home address, mailing address or most recent living situation
- Emergency and/or next of kin contact name, home address and telephone number
- Demographic data
- Determination of need
- Potential housing barriers

Required Forms: Programs must develop the following forms in accordance with State and local guidelines.

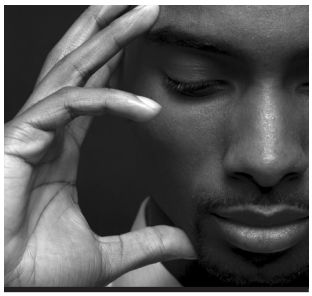
Completed forms are required for each client and will be kept on file in the client chart:

- Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information (specification should be made about what type of information can be released).
- Limits of Confidentiality (Confidentiality Policy)
- Consent to Receive Services
- Patient Rights and Responsibilities
- Patient Grievance Procedures

Along with the forms noted above that are required for all services provided in Los Angeles County, house case management programs may require additional information at intake, including, but not limited to:

- Access Form (detailing specific housing information)
- Grant Request Form (requesting specific housing assistance)
- Household Budget Plan
- Case Management Verification Form – which ensures that a client's case management needs beyond housing assistance are being addressed
- Family Household Documentation — proof of identity for all family members
- Proof of Rental Agreement or Mortgage Statement

STANDARD	MEASURE
Intake process is begun during first contact with client.	Intake tool is completed and in client file.
Eligibility for services is determined.	Patient's file includes: • Documentation of HIV diagnosis • Proof of LA County residency • Verification of financial eligibility • Date of intake • Client name, telephone number, home address, mailing address and or most recent living situation • Emergency and/or next of kin contact name, home address and telephone number • Demographic data • Determination of need • Potential housing barriers
Confidentiality Policy and Release of Information is discussed and completed.	Release of Information signed and dated by client on file and updated annually.
Consent for Services completed.	Signed and dated Consent in client file.
Client is informed of Rights and Responsibilities and Grievance Procedures.	Signed and dated forms in client file.
Housing case management services may also require the following (at minimum): • Access Form • Grant Request Form • Household Budget Plan • Case Management Verification Form • Family Household Documentation • Proof of Rental Agreement or Mortgage Statement	Applicable forms in client file at provider agency.



Programs may include mental health therapy.

COMPRENHENSIVE SCREENING AND REFERRAL

The issues that may affect referral, placement and maintenance of appropriate housing are complex and may encompass varying psychosocial challenges and require careful screening.

Housing case managers play a critical role in assisting homeless and low-income families and individuals living with HIV/AIDS with access to stable housing and supportive services along the entire continuum of care. By helping persons living with HIV/AIDS (PLWHA) secure stable housing, housing case managers make an important contribution in improving the health outcomes of PLWHA. However, to help PLWHA who are homeless or in an unstable housing situation, housing case managers need to work with clients to identify and address a myriad of factors that adversely impact a client's ability to access, secure and maintain stable housing.

These factors may include but are not limited to:

- Steady sources of income
- Access to medical care and treatment adherence,
- Mental health and substance abuse issues
- Lack of independent and/or interpersonal living skills
- Physical or mental abuse
- Immigration status
- History of incarceration

While many housing case managers are primarily focused on addressing the housing needs of clients, success will depend on working with clients to identify and address

these problem areas as part of the service plan. Although housing case managers are not expected to become subject matter experts in each of the above areas, they should be able to quickly screen for these issues and develop a plan for connecting clients to specialists who can address these barriers to stable housing.

Housing case managers should first determine if a client already has medical and/or non-medical (psychosocial) HIV case manager(s) working with the client to ensure that they work as a team to address client needs. If a client does not have an HIV case manager working with him/her, the housing case manager should work with the client to link him/her with one.

Helping clients secure a steady source of income or other public assistance benefits is critical to help clients access and achieve housing stability. However, navigating the myriad of public assistance programs and benefits can be daunting. For this reason, the local continuum of HIV care includes Benefits Specialists whose sole responsibility is to help PLWHA identify, enroll/access, secure, and maintain income and other benefits to which they are entitled. It is imperative that housing case managers work diligently to link clients with Benefits Specialists as part of the client's individualized service plan for housing. Not involving an HIV case manager or a Benefits Specialist will make the job of the housing case manager more difficult and adversely impact the housing prospects and health outcomes of the client.

Housing case managers should be aware of how the psychosocial domains above may affect a client's ability to be appropriately housed, focusing specifically on affordability, habitability, crowding, safety, proximity to medical resources, proximity to community resources (supermarkets, banks, etc.) and the client's social well-being. Such considerations will likely affect the kinds of services to which clients will be referred.

Comprehensive screening will be completed and entered into the County's data management system within 30 days of the initiation of housing case management services.

Client strengths, needs and available resources which could affect referral, placement and maintenance of appropriate housing in the following areas:

- Date of assessment
- Signature and title of staff person completing the assessment
- Client strengths, needs and available resources which could affect referral, placement and maintenance of appropriate housing in the following areas:
- Medical/health care
- Medications
- Adherence issues
- Physical health
- Mental health
- Substance use, history and treatment
- Nutrition/food
- Homelessness
- Family reunification issues
- Child care/safety
- Transportation
- Language/literacy skills
- Cultural factors
- Religious/spiritual support
- Social support system
- Relationship history

- Domestic violence (protection orders, safe housing needs)
- Loss of income
- Financial resources
- Employment
- Education
- Legal issues/incarceration history
- Risk behaviors
- HIV prevention issues
- Environmental factors
- Identified resources and referrals to assist client in areas of need
- Client's housing assessment and date

In addition, as part of the comprehensive screening and referral process, housing case managers will encourage and assist clients to connect to medical care coordination services.

STANDARD	MEASURE

Comprehensive screening will be completed and entered within 30 days of the initiation of services.	Comprehensive screening and referral on file in client chart to include:
	• Date
	• Signature and title of staff person
	• Client strengths, needs and available resources (which could affect referral, placement and maintenance of appropriate housing) in:
	  • Medical/health care
	  • Medications
	  • Adherence issues
	  • Physical health
	  • Mental health
	  • Substance use, history and treatment
	  • Nutrition/food
	  • Homelessness
	  • Family reunification issues
	  • Child care/safety
	  • Transportation
	  • Language/literacy skills
	  • Cultural factors
	  • Religious/spiritual support
	  • Social support system
	  • Relationship history
	  • Domestic violence (protection orders, safe housing)
	  • Loss of income
	  • Financial resources
	  • Employment
	  • Education
	  • Legal issues/incarceration history
	  • Risk behaviors
	  • HIV prevention issues
	  • Environmental factors
	• Resources and referrals
	• Client's housing stability assessment

HOUSING ASSESSMENT

Client housing assessments will be completed using all components of the initial comprehensive screening and based upon a client's level of functioning and/or current need. Housing assessments will be used to determine the client's current and future housing needs and the types of housing assistance that will help stabilize the client in housing.

Supportive services include food and nutrition.

Housing case managers should gather the following information about a client's temporary and permanent housing needs, finances, housing history, behavioral/legal history and other service needs to conduct a thorough housing assessment:

- **Temporary housing needs:** Homelessness status, ability to afford current housing, inappropriate or sub-standard housing, medical/mental health needs, physical accessibility, household size/composition and location considerations
- **Permanent housing needs:** Affordability, homeownership, named tenant on lease, family reunification, medical/mental health needs, physical accessibility, household size/composition and location considerations
- **Finances:**
  - Public and private benefits: Benefits currently receiving, eligibility for mainstream programs, protective payee services, expectation for future benefits/income
  - Employment: Work history, skills/education for potential employment
  - Credit problems: Lack of credit or poor credit history and bankruptcy
- **Housing history:** Successful rental history, positive references from prior landlords, experience of living independently, homelessness and evictions or problems with tenancy
- **Behavioral/legal issues:**
  - **Criminal justice:** Prior offenses and currently on parole/probation
  - **Mental health issues:** Connection to care/services, ability to manage care, ability to manage symptoms, life skills competency, and anti-social behavior
  - **Substance use/abuse:** Use history, awareness of relapse patterns, treatment history and interest in treatment/sobriety
  - **Special behavioral issues:** Fire setting, homicide, dealing illegal substances, verbal or physical aggression, suicidal or self-injurious behavior, history of harassing/stalking and sex offenses
- **Other service needs:**
  - **Illness and disability:** HIV confidentiality, equipment/furnishings, live-in personal care attendant, service animal and proximity to health care/services
  - **Independent living skills:** Self-care, transportation, negotiation and mediation skills, cleaning and maintaining housing unit, budgeting and financial literacy and managing nutritional needs
  - **Family and social supports**: Connections to family and other significant people, intent to reunify with children or family

The housing assessment assigns clients into one of three categories:

- **Stable housing:** Housing in the private rental or homeownership markets with reasonable expectation that additional support is not currently needed, or other HOPWA-funded assistance other than short-term rent, mortgage, utility grant (STRMU)
- **Unstable housing**
  - **Temporary housing:** Including moving in with family/friends, continued STRMU assistance, transitional housing for homeless and temporary placement in an institution (e.g., hospital, substance abuse residential facility) — avoids homelessness, but likely to need more support
  - **Unstable situations:** Including emergency shelters or habitation in places not intended for occupancy (e.g., vehicle, abandoned building, bus station, any place outside), known to be homeless, in jail or disconnected from the system

STANDARD	MEASURE
Housing assessments will be performed on all clients.	Completed housing assessment on file in client chart.
Clients will be reassessed at least once every six months.	Program monitoring and chart review to confirm.

INDIVIDUAL HOUSING PLAN (IHP)

Information gathered in the comprehensive screening and housing assessments will be used to develop the client's IHP. Working closely with the client, the housing case manager will formulate a housing plan tailored to the specific needs of the client. The primary focus of the IHP is long-term housing stability. The IHP should identify the client's ongoing housing stability needs, realistic housing and service options, client resources and reasons for the housing need. The IHP should also describe how short-term or transitional housing will lead to a permanent housing arrangement.

IHP goals should be developed for maximum commitment by the client and be future oriented.

Goals should be established for securing and maintaining appropriate housing and linkages to the following appropriate supportive services:

- Income/benefits/employment
- Independent living skills
- Budget and money management
- Transportation
- Food and nutrition
- Mental health/substance use treatment
- Access to primary medical care
- Child care
- Family connections

Goals should have specific outcomes for achievement, a timeframe for completion, the support needed to achieve the goals, the tasks to be accomplished by the client and housing case manager and client commitments.

Whenever possible, housing case managers will make every effort to secure housing in a client's current community. Housing plans should take care to preserve a client's existing family unit as well as to accommodate a client's legal right to retain assistance animals.

IHPs will be completed for each client within two weeks of the conclusion of the psychosocial assessment.

The IHP will include (at minimum):

- Name of client and housing case manager
- Date and signature of housing case manager
- Date and signature of the client on the initial IHP, and not less than once every six months on subsequent IHPs
- Relevant current housing information and needs
- Description of current housing problem and barriers pertaining to housing
- Description of housing goals
- Steps to be taken by client, housing case manager and others to accomplish goals (including linked referrals)

STANDARD	MEASURE
IHPs will be developed in conjunction with the client within two weeks of completing the comprehensive screening.	IHP on file in client chart to include: • Name of client and housing case manager • Date and signature of housing case manager and client • Relevant current housing information and needs • Current housing problem and barriers pertaining to housing • Date and description of client goals and desired outcomes • Action steps to be taken by client, case manager and others

IMPLEMENTATION OF IHP, EVALUATION, MONITORING AND UPDATING

Implementation, evaluation, monitoring and updating of the IHP involve ongoing contact and interventions with (or on behalf of) the client to achieve the goals detailed in the IHP, evaluate whether services are consistent with the IHP and determine any changes in the client's circumstances (e.g., health status, family composition, income/employment, behavioral health needs) that could impact the IHP. These activities ensure that referrals are completed and services are obtained in a timely, coordinated fashion.

IHPs will be updated on an ongoing basis or when the client's conditions/needs change, but not less than once every six months. Updates to the IHP will include revised timeframes and client and housing case manager responsibilities.

Plan updates will be prompted by the following events:

- Significant changes occur in the client's income or household status
- Receiving time limited services such as HOPWA STRMU
- Annual Section 8 or HOPWA Tenant-Based Rental Assistance (TBRA) income recertifications
- Client leaving and re-entering services

In the implementation, evaluation, monitoring and updating phases, housing case managers are responsible for (at minimum):

- Identifying and coordinating any assistance needed to accomplish the IHP, including skills deficits, budgeting support and negotiating health care or behavioral health.
- Assisting clients in the housing search process including but not limited to accompanying and assisting individuals with housing searches and identifying potential shared housing opportunities when appropriate
- Making appropriate housing referrals and coordinating the full spectrum of available housing services, including, but not limited to:
  - Short-term rental assistance
  - Transitional housing programs
  - Emergency shelters
  - Section 8 or low income housing TBRA
  - Sober living programs
  - Mental health/dual diagnosis facilities
  - Group home environments
  - Domestic violence shelters
  - Private housing
  - Shelter Plus Care (S + C)
  - Permanent housing with supportive services
  - SROs (Single Room Occupancy housing)

    - Hotels and motels
    - Licensed facilities
    - Roommate referral
- Assisting clients with gathering necessary documentation and helping to complete housing applications (e.g., Section 8 applications)
- Advocating and negotiating for clients with poor credit and/or poor housing histories
- Assisting clients prepare for interviews with housing managers and property owners
- Educating clients about tenant rights and responsibilities
- Educating clients about specific eligibility criteria for each type of housing referral
- Working closely with a client's psychosocial case manager or care coordinator to assist with housing retention efforts and facility communication among involved parties
- Maintaining ongoing client contact (preferably face-to-face) according to the following guidelines:
    - **Stable housing:** A minimum of one contact attempted every three months
    - **Unstable housing:**
        - **Temporary housing:** A minimum of two contacts attempted every month
        - **Unstable situations:** As many contacts as necessary to obtain temporary or stable housing, but at minimum, weekly. For those clients already in emergency housing – a minimum of two contacts attempted every month.
- Actively following up by the end of the next business day with clients who have missed a housing case management appointment. If follow-up activities are not appropriate or cannot be conducted within the prescribed time period, housing case managers will document reason(s) for the delay.

Current dated and signed progress notes, detailing activities related to implementing, evaluating, monitoring and updating of the IHP, will be kept on file in the client chart.

The following documentation is required (at minimum):

- Description of all client contacts, attempted contacts and actions taken on behalf of the client
- Date and type of contact
- Description of what occurred during the contact
- Changes in the client's condition or circumstances
- Progress made towards achieving goals identified in the IHP
- Barriers identified in IHP goal process and actions taken to resolve them
- Linked referrals and interventions provided
- Current status and results of linked referrals and interventions
- Barriers identified in completing linked referrals and actions taken to resolve them
- Time spent with, or on behalf of, the client
- Case manager's signature and professional title

STANDARD	MEASURE
Housing case managers will: • Identify and coordinate assistance • Assist clients in housing search • Make appropriate housing referrals and coordinate available housing services • Assist clients in application process • Advocate and negotiate for clients with poor credit/housing histories • Assist clients in preparing for housing interviews • Educate clients about tenant rights and responsibilities • Educate clients about specific eligibility criteria • Coordinate housing efforts with case manager/care coordinator • Maintain client contact in conjunction with frequencies outlined in the housing stability assessment • Follow up missed appointments by the end of the next business day	Signed, dated progress notes on file that detail (at minimum): • Description of client contacts and actions taken • Date and type of contact • Description of what occurred • Changes in the client's condition or circumstances • Progress made toward IHP goals • Barriers to IHPs and actions taken to resolve them • Linked referrals and interventions and current status/ results of same • Barriers to referrals and interventions/actions taken • Time spent • Housing case manager's signature and title

CLIENT RETENTION

Programs shall strive to retain clients in housing case management services. To ensure continuity of service and client retention, programs will be required to establish a broken appointment policy. Follow-up strives to maintain a client's participation in care and can include telephone calls, written correspondence and/or direct contact. Such efforts shall be documented in the progress notes within the client record.

In addition, programs will develop and implement a contact policy and procedure to ensure that clients/families who are homeless or report no contact information are not lost to follow-up.

STANDARD	MEASURE
Programs shall develop a broken appointment policy to ensure continuity of service and retention of clients.	Written policy on file at provider agency.
Programs shall provide regular follow-up procedures to encourage and help maintain a client in case management services.	Documentation of attempts to contact in signed, dated progress notes. Follow-up may include: • Telephone calls • Written correspondence • Direct contact
Programs will develop and implement client contact policy for homeless clients and those with no contact information	Contact policy on file at provider agency. Program review and monitoring to confirm.

CASE CLOSURE

Case closure is a systematic process for disenrolling clients/families from active housing case management services. The process includes formally notifying clients of pending case closure and completing a case closure summary to be kept on file in the client chart. All attempts to contact the client and notifications about case closure will be documented in the client file, along with the reason for case closure. Missed appointments should never be the sole reason for case closure.

Cases may be closed for the following reasons:

- IHP goals were met and client housing needs were resolved
- Client relocation outside of the service area
- Continued non-adherence to the IHP
- Inability to contact client
- Client incarceration
- Voluntary termination of services by client
- Unacceptable threatening client behavior
- Client death
- Lack of/inability to contact client over 180 days

Case closure summaries will be reviewed, approved and signed and dated by the housing case management supervisor. When appropriate, such summaries will include a plan for client's continued success and ongoing resources to be utilized.

At minimum, case closure summaries will include:

- Date and signature of case manager
- Date of case closure
- Housing stability assessment at time of case closure
- Status of the IHP
- Referrals provided
- Reasons for disenrollment and criteria for re-entry into services

STANDARD	MEASURE
Clients will be formally notified of pending case closure.	Contact attempts and notification about case closure on file in client/family chart.
Case management cases may be closed for the following reasons: • IHP goals were met • Client relocation • Continued non-adherence • Inability to contact client/family • Client incarceration • Voluntary termination by client • Unacceptable or threatening client behavior • Client death • Lack of/inability to contact client over 180 days	Case closure summary on file in client/family chart to include: • Date and signature of case manager • Date of case closure • Housing stability assessment • IHP status • Referrals provided • Reason for closure • Criteria for re-entry into services • Signature and date of client care supervisor

HOUSING COORDINATION

Housing case managers must also market their housing services to new and existing private, public, nonprofit, and/or for-profit agencies/owners/managers in the housing case manager's geographic area. The goal of marketing is to expand the number of property owners willing to provide housing to HIV-positive clients and to establish channels of communication to identify and address concerns before a client's housing stability is threatened.

Housing case manager programs will develop, maintain and share a list of agencies/owners/managers who are willing to rent their properties to HIV-positive clients. They will share this list with other agencies, the City of Los Angeles and the County of Los Angeles (http://www.chirp.la.org (for HIV-positive individuals looking for housing) and http://housing.lacounty.org (for anyone looking for housing, including HIV-positive individuals) at least once a month to ensure they maintain the most comprehensive information available.

Housing case managers are responsible for (at minimum):

- Providing housing information and resources to people living with HIV in their respective geographic areas
- Contacting four new private, public, nonprofit, or for-profit agencies/owners/managers per month
- Maintaining accurate, up-to-date lists of available and appropriate housing
- Serving as liaison between property owners/managers and client to ensure safety, maintenance and habitability standards, and positive relationships
- Maintaining open and positive channels of communication with property owners/managers to identify and address concerns before client's housing stability is threatened
- Engaging in landlord retention efforts

STANDARD	MEASURE
Housing case managers will provide housing information and referrals to clients.	IHP on file in client chart includes housing information and referrals given to client.
Housing case managers will contact at least four private, public, nonprofit, or for-profit agencies/owners/managers per month.	Number of new agencies/owners/managers contacted per month on file at provider agency.
Housing case managers will maintain accurate, up-to-date lists of available and appropriate housing in their geographic area.	Current up-to-date lists of available and appropriate housing in their geographic area on file at provider agency.
Housing case management programs will share their up-to-date lists of available and appropriate housing with other agencies, the City of Los Angeles and the County of Los Angeles on an ongoing basis but at minimum once a month.	Documentation of when and what property owner information shared with other agencies, the City of Los Angeles and the County of Los Angeles on file at provider agency.
Housing case managers will serve as a liaison between property owners or managers and client.	IHP on file in client chart includes notes regarding description of contacts between owners/managers and client.
Housing case managers will maintain open and positive channels of communication with property owners or managers.	Description of communication with property owners or managers on file at provider agency.
Housing case managers will engage in landlord retention efforts.	Description of landlord retention efforts on file at provider agency.

STAFFING REQUIREMENTS AND QUALIFICATIONS

At minimum, all housing case management staff will be able to provide linguistically and culturally age-appropriate care to people living with HIV and complete documentation as required by their positions. Housing case management staff will complete an agency-based orientation before providing services. Staff will also be trained and oriented regarding client confidentiality and HIPAA regulations.

Housing case managers will hold a Bachelor's degree in an area of human services; a high school diploma (or general education development (GED) equivalent) and at least one year's experience working as an HIV case manager; or at least three years' experience working in a related health services field.

Further, housing case management staff will have:

- Knowledge of HIV/AIDS and related issues
- Knowledge of the Los Angeles County HIV continuum of care and the role of housing case management in the HIV continuum of care

- Effective interviewing and assessment skills
- Ability to appropriately interact and collaborate with others
- Effective written/verbal communication skills
- Ability to work independently
- Effective problem-solving skills
- Ability to respond appropriately in crisis situations
- Effective organizational skills

All housing case managers will complete DHSP's Benefits Specialty 101 training and, requisite HOPWA and HUD trainings as required by the Los Angeles Housing Department.

Client care case management supervision will be provided by a Master's degree-level mental health professional (social work, counseling, nursing with specialized mental health training, psychology, or doctoral candidate in any of these fields) with case management experience and appropriate professional credentials. Case management supervisors will complete DHSP's Case Management Supervisor Training within six months of being hired.

Housing case managers will perform their duties according to generally accepted ethical standards including:

- Striving to maintain and improve professional knowledge, skills and abilities
- Basing all services on assessment, evaluation or diagnosis of clients
- Providing clients with a clear description of services, timelines and possible outcomes at the initiation of services
- Safeguarding a client's rights to confidentiality within the limits of the law
- Evaluating a client's progress on a continuous basis to guide service delivery
- Referring clients for those services that the case manager is unable to provide and terminating service with a client when the service is no longer in the client's best interest

CLIENT CARE-RELATED SUPERVISION

Supervision is required of all housing case managers in order to provide guidance and support. Client care-related supervision will be provided for all housing case managers at a minimum of two hours per month. Such client care-related supervision may be conducted in individual or group/multidisciplinary team case conference formats. This supervision may be provided in-house by existing staff, or in conjunction with other agencies in a larger group format. Supervision will be provided by a Master's degree-level mental health professional (social work, counseling, nursing with specialized mental health training, psychology, or Doctoral candidate in any of these fields) with case management experience and appropriate professional credentials.

Client care-related supervision will address clients' psychosocial issues and concerns and their effect on a clients ability to secure and maintain appropriate housing. Supervision help problem-solving related to clients' progress towards goals detailed in the IHP and ensure that high quality housing case management services are being provided.

Client care-related supervision will include the following required documentation to be kept on file in the client chart:

- Date of client care supervision
- Supervision format (e.g., individual, group, case conference or multidisciplinary team case conference

- Name and title of participants
- Psychosocial issues and concerns identified
- Description of guidance provided and housing case management follow-up plan
- Verification that guidance provided and follow-up plan have been implemented
- Client care supervisor's name, title and signature

STAFF DEVELOPMENT AND ENHANCEMENT ACTIVITIES

Periodic staff training is required to ensure the continued delivery of quality services. Programs will provide and/or allow access to ongoing staff development and training for housing case management staff. Staff development and enhancement activities will include (but not be limited to) trainings and/or in-services related to housing case management issues and HIV/AIDS, including DHSP's Case Management Re-Certification Training Program and required re-certification trainings from HOPWA and HUD. Housing case managers will participate in at least eight hours of job-related education or training annually.

The following documentation, to be kept in the employee record, is required for staff development and enhancement activities:

- Date, time and location of function
- Function type
- Staff member(s) name(s) attending function
- Name of sponsor or provider of function
- Training outline
- Meeting agenda and/or minutes

STANDARD	MEASURE
Housing case management programs will hire staff that are able to provide age and culturally appropriate care to clients infected with and affected by HIV.	Resume on file at provider agency to confirm.
All staff will be given orientation prior to providing services.	Record of orientation in employee file at provider agency.
Case management staff will complete DHSP's Case Management Certification Training within six months of being hired as well as HOPWA and HUD trainings. Case management supervisors will complete the Supervisors' Training within six months of being hired.	Documentation of Certification completion maintained in employee file.
Staff will participate in re-certification training as required by DHSP, HOPWA, and HUD and in at least eight hours of continuing education annually .	Documentation of training maintained in employee files to include: • Date, time and location of function • Function type • Staff members attending • Sponsor or provider of function • Training outline • Meeting agenda and/or minutes
Housing case managers will practice according to generally accepted ethical standards.	Program review and monitoring to confirm.

STANDARD	MEASURE
Housing case management staff will receive a minimum of two hours of client care-related supervision per month from a Master's degree-level mental health professional	All client care-related supervision will be documented as follows (at minimum): • Date of client care supervision • Supervision format • Name and title of participants • Issues and concerns identified • Guidance provided and follow-up plan • Verification that guidance and plan have been implemented • Client care supervisors name, title and signature
Client care-related supervision will provide general guidance and follow up plans for housing case management staff.	Documentation of client care supervision for individual clients will be maintained in the client's individual file.

UNITS OF SERVICE

Unit of service: Units of service defined as reimbursement for housing case management services are based on services provided to eligible clients.

- ***Individual intake and assessment units:*** calculated in number of hours provided
- ***IHP development units:*** calculated in number of hours provided
- ***IHP implementation, evaluation, monitoring and updating units:*** calculated in number of hours provided

Number of clients: Client numbers are documented using the figures for unduplicated clients within a given contract period.

REFERENCES

Chernesky, R.H., and Grube, B. (2000). Examining the HIV/AIDS case management process. *Health & Social Work*, 25 (4), 243-253.

County of Los Angeles, HIV Epidemiology Program. (2008). *HIV/AIDS Semi-Annual Surveillance Survey* (available online at http://lapublichealth.org/wwwfiles/ph/hae/hiv/HIVAIDS%20semiannual%20surveillance%20summary_January2008.pdf) Department of Health Services, Los Angeles.

Gardner, L.I., Metsch, L.R., Anderson-Mahoney, P., et al. (2005). Efficacy of a brief case management intervention to link recently diagnosed HIV-infected persons to care. *AIDS*, 19 (4), 423-431.

Kenagy, G.P., Linsk, N.L., Bruce, D., et al. (2003). Service utilization, service barriers, and gender among HIV-positive consumers in primary care. *AIDS Patient Care and STDs*, 17 (5), 235-244.

Masson, C.L., Sorensen, J.L., Phibbs, C.S., et al. (2004). Predictors of medical service utilization among individuals with co-occurring HIV infection and substance abuse disorders. *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, 16 (6), 744-755.

Messeri, P.A., Abramson, D.M., Aidala, A.A,. et al. (2002). The impact of ancillary HIV services on engagement in medical care in New York City. *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, 14 (Suppl. 1), S15-S29.

Mitchell, C.G., and Linsk, N.L. (2001). Prevention for positives: Challenges and opportunities for integrating prevention into HIV case management. *AIDS Education and Prevention*, 13 (5), 393-402.

Molitor, F., Kuenneth, C., Waltermeyer, J., et al. (2005). Linking HIV-infected persons of color and injection drug users to HIV medical and other services: The California Bridge Project. *AIDS Patient Care and STDs*, 19 (6), 406-412.

Smith, M.Y., Rapkin, B.D., Winkel, G., et al. (2000). Housing status and health care service utilization among low-income persons with HIV/AIDS. *Journal of General Internal Medicine*, 15 (10), 731-738.

Spire, B., Duran, S., Souville, M., et al. (2002). Adherence to highly active antiretroviral therapies (HAART) in HIV-infected patients: from a predictive to a dynamic approach. *Social Science & Medicine*, 54 (10), 1481-1496.

Waldrop-Valverde, D, and Valverde, E. (2005). Homelessness and psychological distress as contributors to antiretroviral nonadherence in HIV-positive injecting drug users. *AIDS Patient Care and STDs*, 19 (5), 326-334.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
DHSP	Division of HIV and STD Programs
GED	General Education Development
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HUD	Housing and Urban Development
IHP	Individual Housing Plan
LA	Los Angeles
PLWHA	People Living with HIV/AIDS
RN	Registered Nurse
S+C	Shelter Plus Care
SRO	Single Room Occupancy
STD	Sexually Transmitted Disease
STRMU	Short-Term Rent, Mortgage, Utility Grant
TBRA	Tenant-Based Rental Assistance